

First Look

Preliminary Inquiry for Insurance



888-850-8334

Fax **704-542-2616**

www.zenithmarketing.com



8334 Pineville Matthews Road
PMB 103-113
Charlotte, NC 28226

PRELIMINARY INQUIRY

NOT AN APPLICATION FOR INSURANCE



Zenith Marketing Group Inc.

(888) 850-8334 Fax: (704) 542-2616

www.zenithmarketing.com

Page 1 of 5

PERSONAL HISTORY

Name (First, MI, Last):

- Male
 Female

Date of Birth (MM/DD/YYYY)

Current Age:

Soc. Sec. #

Driver's License # / State

Street Address

City

State

Zip

Occupation

Annual Earned Income

Duties

Net Worth

REQUESTED PLAN OF INSURANCE

Minimum consideration \$500,000 death benefit and \$5,000 premium

- Universal Life Whole Life

Term, Level Period: _____ Survivorship* Long Term Care

Disability Income, Monthly Benefit: _____

Face amount desired

Premium amount desired

Rate class desired

What is the purpose of the insurance?

Name of beneficiary

Relationship

*If both have insurability questions - complete this form on each life

PENDING AND IN FORCE COVERAGE None

Company	Issue or Application Date	Amount	Final Action/ Risk Classification	Annual Premium	Replacement Planned?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Outcome and offer from your primary carrier? _____

Are you working with any other Impaired Risk Agencies on this case? Yes: _____ No

Has this case been discussed with anyone at Zenith Marketing Group, Inc.? Yes: _____ No

Total amount to be accepted from all sources? _____

Are there any carriers that should be excluded from consideration? Yes: _____ No

Is the case being premium financed? Yes: _____ No

Are you aware of any other information or special circumstances that would have an impact on Underwriting? Yes: _____ No

AGENT INFORMATION

Name

Soc. Sec. #

Phone #

Fax #

E-Mail Address

Street Address

City

State

Zip

Proposed Insured: _____ Soc. Sec. #: _____

MEDICAL HISTORY

Height: _____ feet _____ inches Weight: _____ pounds

Name, Address, & Phone Number of Personal Physician

Date Last Consulted	Reason Last Consulted
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>

Medication Prescribed	Advice & Treatment Given
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>

OTHER MEDICAL TESTS - provide details for all that apply:

Test	Date(s)	Results <i>If abnormal, please provide details</i>
Blood Pressure		
Cholesterol		Total: _____mg Cholesterol/HDL Ratio _____
EKG		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
X-ray		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Colonoscopy		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Mammogram (women only)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Prostate Exam (men only)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Prostate Specific Antigen (PSA) (men only)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

*Details of other medical tests and additional medical facilities consulted within the last 10 years.
Provide dates, diagnosis, details, treatment, plus names, addresses & phone numbers for all physicians/medical facilities.*

Proposed Insured: _____ Soc. Sec. #: _____

CHEST PAIN - CORONARY *Not Applicable*

Date of diagnosis or first onset of symptoms: ___/___/___.
Heart Attack? Yes, Date: _____ No

Surgery:	Any symptoms post-operatively?
<input type="checkbox"/> Angioplasty, Date: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bypass, Date: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Valve Replacement, Date: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No

Number of diseased vessels: _____

Date of last Stress EKG: ___/___/___

Results: Normal Abnormal: (provide details):

Date of last Echocardiogram ___/___/___

Results: Normal Abnormal: (provide details):

Arrhythmias? Yes (provide details) No

Heart enlargement? Yes (provide details) No

DIABETES *Not Applicable*

Date of Diagnosis: _____ Age@ Diagnosis: _____

Treatment: Diet Only Oral Medication Insulin

Dosage and Details:

Blood Glucose Levels: Checked @ Home? Yes No
Results: _____
Frequency: _____
Last Glycohemoglobin level: _____ mg%
(Hemoglobin A1c)
Date: _____

Ever Had: Protein in urine? Yes No Microalbumin in urine? Yes No
Eye Trouble? Yes No Kidney Trouble? Yes No
Heart Trouble? Yes No Neuritis or neuralgia? Yes No
High Blood Pressure? Yes No Insulin Reactions? Yes No

CANCER *Not Applicable*

Name of Cancer (i.e. carcinoma, sarcoma, melanoma, etc.)

Location of Cancer

Date of Diagnosis

Date of Last Treatment

Type(s) of Treatment: (check all that apply & provide dates of treatment)

<input type="checkbox"/> Surgery _____	<input type="checkbox"/> Radiation _____
<input type="checkbox"/> Chemotherapy _____	<input type="checkbox"/> Hormone Therapy _____
<input type="checkbox"/> Immunotherapy _____	<input type="checkbox"/> Other: _____

Stage of Cancer

Grade of Cancer

<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Other: _____	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Other: _____
<input type="checkbox"/> A <input type="checkbox"/> A1 <input type="checkbox"/> A2	
<input type="checkbox"/> B <input type="checkbox"/> B1 <input type="checkbox"/> B2	
<input type="checkbox"/> C <input type="checkbox"/> C1 <input type="checkbox"/> C2	
<input type="checkbox"/> D <input type="checkbox"/> D1 <input type="checkbox"/> D2	

Metastasis? Lymph Nodes: _____ Other Organs Tissues: _____

Recurrence? Yes (provide details):

No

Current Medications:
(include frequency and dosage)

FAMILY HISTORY OF PROPOSED INSURED

Have any immediate family members (parents, siblings) been diagnosed with or died from complications from circulatory disorders, heart disease, or cancer?

Yes No

(If yes, please include details below)

	Age (if living)	Age at death	Onset age of disease	Details
Father				
Mother				
Brothers				
Sisters				

Proposed Insured: _____ Soc. Sec. #: _____

DRUG AND ALCOHOL USE Not Applicable

Do you currently drink alcohol? Yes No
Provide details below

Did you ever drink substantially more than you do at the present time? Yes No
Provide details below

Type:	Amount Per Week
Beer	
Wine	
Liquor	

Type:	Amount Per Week
Beer	
Wine	
Liquor	

Have you ever consulted a physician for your alcohol use? Yes No
Physician/facility, Dates, and Details

Have you ever been arrested for driving under the influence of alcohol or drugs? Yes No
Dates, and Details

Have you ever had a problem or received treatment for drug use? Yes No
Types of Drugs Used

Treatment Date(s)

Date Last Used

Are you attending recovery group meetings? Yes No
 Alcoholics Anonymous Narcotics Anonymous Other: _____

TOBACCO AND NICOTINE USE

		Quantity	Frequency	Date Last Used
a) Have you ever used cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
b) Have you ever used any other form of tobacco products?	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify type(s): <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> Chew <input type="checkbox"/> Snuff <input type="checkbox"/> Nicorette gum <input type="checkbox"/> Nicotine patch <input type="checkbox"/> Other: _____			

AVIATION AND HOBBIES Not Applicable

Type: Private Commercial

Total Hours Experience:

Hours Flown Per Year: Last Year: This Year:

Check if Applicable

IFR
 VFR
 Student

Do you participate in any hazardous activities?
 Yes (provide details below and applicable questionnaire) No

Ultralight Flying Bungee Jumping Scuba Diving Auto/Cycle Racing
 Sky Diving Hang Gliding Mountain Climbing Other: _____

Proposed Insured: _____ Soc. Sec. #: _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
 (This authorization complies with HIPAA Privacy Rules)
Provide a signed copy to the Proposed Insured

This authorization will permit Zenith Marketing Group, Inc. to obtain and release nonpublic personal information about me, the proposed insured named below, for the purpose of determining my eligibility for and obtaining insurance products and services from one or more of the insurers or other institutions ("the companies") listed below. Information that may be released to and disclosed by Zenith Marketing Group, Inc. and the companies listed below pursuant to this authorization shall include any and all information, to the extent permitted by applicable law.

Information to be released pursuant to this authorization includes any personal health information, records or data concerning my past, present or future mental, physical, or behavioral health or condition ("Information"), to the extent permitted by law. "Information" includes all information, records, or data relating to my: physical or mental history or condition, medical treatment, diagnosis, or prognosis, including medications prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances, occupation, avocation, including any hazardous hobbies, driving records, aviation activities, and other personal traits.

I understand that this information may include results from blood, saliva, urine, and other tests. I further understand that this information may, if applicable, include information regarding diagnosis, prognosis, and treatment of: alcohol or drug abuse (including records protected under federal law, 42 CFR Part 2), serious communicable disease or infection, including sexually transmitted diseases, HIV infection, including medical tests results.

I authorize any physician, health care provider, health plan, medical professional, hospital, clinic, medical testing laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB, Inc.) or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers"), consumer reporting agency, and any state Motor Vehicle Department to disclose the entire medical records and any other protected health information concerning me to release information about me to Zenith Marketing Group Inc., the companies referenced below ("the companies"), their agents, affiliates, employees, and third party representatives. I also authorize the MIB to release information directly to any company, provided the insurer is a member of the MIB.

I understand that information disclosed to Zenith Marketing Group may have been subject to state and federal privacy laws and regulations. Once information is disclosed to Zenith Marketing Group Inc., it may no longer be subject to those laws and regulations. I understand that if I refuse to sign this Authorization to release my complete medical records, Zenith Marketing Group, Inc. may not be able to process my request.

A photocopy of this authorization shall be as valid as the original. This authorization shall remain in force for 24 months following the date of my signature below, unless revoked by me in writing and written notice of the revocation is provided to Zenith Marketing Group, Inc., 303 West Main Street, Suite 200, Freehold, NJ 07728. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. Any action taken prior to the notice of revocation shall be valid.

I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured or Authorized Representative _____

Date _____

If signed by Authorized Representative, describe authority (i.e. parent or guardian of a minor child, etc.) and relationship to Proposed Insured

Printed Name of Proposed Insured _____

Social Security # _____

Date of Birth _____

Address of Proposed Insured _____

Name of Agent

21 st Services AI Credit AIG AIG of NY Allianz Allianz of NY Allstate of NY American General American General of NY American National APFS Assurity AXA Equitable Aviva AVS Underwriting	Banner Life Cambridge Financing Chase Insurance Clinical Reference Lab (CRL) CMS II Companion of NY Concord Capital Funding Coventry First Credit Suisse EMSI Enterprise Bank & Trust ExamOne Express Imaging Services First Penn Pacific	First MetLife Investors Fort Dearborn Fortris Genworth Life and Annuity Genworth Life of NY Goldman Sachs Guardian ING/USA Insurative Premium Finance John Hancock Life of the Southwest Lincoln Benefit Life Lincoln Financial Group Longboat Funding Massachusetts Mutual	MetLife Mutual of Omaha National Life Insurance Company Nationwide Financial North American Life & Health North American Life & Health of NY Old Mutual Peachtree Life Settlements Penn Mutual PFG HYBRID Phoenix Life Portamedic Presidential Principal Financial Group Protective Life & Annuity of NY	Pruco Life Insurance Company Pruco Life Insurance Co. of NJ Prudential Insurance Co. of America Reliastar Reliastar of NY Ridge Capital Flexible Premium Finance SBLI of Mass. Security Life of Denver Security Mutual Security Mutual of NY Sentinel Settlement Benefits Assoc. Southland Standard	Sun Life Financial Transamerica Union Central United of Omaha US Life of NY West Coast William Penn Zenith Marketing Group
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MARKETING GROUP INC.

8334 Pineville Matthews Road, PMB 103-113

Charlotte, NC 28226

(888) 850-8334 • Fax: (704) 542-2616

www.zenithmarketing.com



CLIENT'S COPY



Proposed Insured: _____ Soc. Sec. #: _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
(This authorization complies with HIPAA Privacy Rules)
Provide a signed copy to the Proposed Insured

This authorization will permit Zenith Marketing Group, Inc. to obtain and release nonpublic personal information about me, the proposed insured named below, for the purpose of determining my eligibility for and obtaining insurance products and services from one or more of the insurers or other institutions ("the companies") listed below.

Information to be released pursuant to this authorization includes any personal health information, records or data concerning my past, present or future mental, physical, or behavioral health or condition ("Information"), to the extent permitted by law.

I understand that this information may include results from blood, saliva, urine, and other tests. I further understand that this information may, if applicable, include information regarding diagnosis, prognosis, and treatment of: alcohol or drug abuse (including records protected under federal law, 42 CFR Part 2), serious communicable disease or infection, including sexually transmitted diseases, HIV infection, including medical tests results.

I authorize any physician, health care provider, health plan, medical professional, hospital, clinic, medical testing laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB, Inc.) or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers"), consumer reporting agency, and any state Motor Vehicle Department to disclose the entire medical records and any other protected health information concerning me to release information about me to Zenith Marketing Group Inc., the companies referenced below ("the companies"), their agents, affiliates, employees, and third party representatives.

I understand that information disclosed to Zenith Marketing Group may have been subject to state and federal privacy laws and regulations. Once information is disclosed to Zenith Marketing Group Inc., it may no longer be subject to those laws and regulations. I understand that if I refuse to sign this Authorization to release my complete medical records, Zenith Marketing Group, Inc. may not be able to process my request.

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Signature of Proposed Insured or Authorized Representative

Date

If signed by Authorized Representative, describe authority (i.e. parent or guardian of a minor child, etc.) and relationship to Proposed Insured

Printed Name of Proposed Insured

Social Security #

Date of Birth

Address of Proposed Insured

Name of Agent

- 21st Services, Banner Life, First MetLife Investors, MetLife, Pruco Life Insurance Company, Sun Life Financial
AI Credit, Cambridge Financing, Fort Dearborn, Mutual of Omaha, Pruco Life Insurance Co. of NJ, Transamerica
AIG, Chase Insurance, Fortris, National Life Insurance Company, Prudential Insurance Co. of America, Union Central
AIG of NY, Clinical Reference Lab, Genworth Life and Annuity, Nationwide Financial, Reliastar, Reliastar of NY, United of Omaha
Allianz, (CRL), Genworth Life of NY, North American Life & Health, Reliastar of NY, US Life of NY
Allianz of NY, CMS II, Goldman Sachs, North American Life & Health of NY, Ridge Capital Flexible, West Coast
Allstate of NY, Companion of NY, Guardian, Old Mutual, Premium Finance, William Penn
American General, Concord Capital Funding, ING/USA, Peachtree Life Settlements, SBLI of Mass., Zenith Marketing Group
American General of NY, Coventry First, Insurative Premium Finance, Penn Mutual, Security Life of Denver
American National, Credit Suisse, John Hancock, PFG HYBRID, Security Mutual
APPS, EMSI, Life of the Southwest, Phoenix Life, Security Mutual of NY
Assurity, Enterprise Bank & Trust, Lincoln Benefit Life, Portamedic, Sentinel
AXA Equitable, ExamOne, Lincoln Financial Group, Express Imaging Services, Presidential, Settlement Benefits Assoc.
Aviva, Express Imaging Services, Longboat Funding, First Penn Pacific, Massachusetts Mutual, Principal Financial Group, Southland
AVS Underwriting, First Penn Pacific, Massachusetts Mutual, Protective Life & Annuity of NY, Standard

Proposed Insured: _____ Soc. Sec. #: _____

INSTRUCTIONS TO AGENT: THE NOTIFICATION APPEARING BELOW MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE.**NOTICE TO PROPOSED INSURED**

In connections with your informal inquiry about insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed in connection with preparation of this report. Upon written request to the life insurance companies listed in this Notice, you will be informed whether or not an investigative consumer report was requested, and if so, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as to the nature and scope of its investigation. You have the right to inspect a copy of any such report by contacting the consumer reporting agency.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this notice or their reinsurers may, however, make a brief report thereon the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an informational exchange bureau on behalf of its member. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112 Tel. (617) 426-3660.

The companies listed in this Notice or their reinsurers may also release information in their files to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, the listed insurance companies will rely heavily on information provided by you. The companies may also seek information from others, such as medical professionals, who have treated you.

You have the right to be told about, and to see and copy, if you wish, items of personal information about you which appear in the insurance companies file, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE LISTED INSURANCE COMPANIES AND YOUR AGENT'S INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR WRITTEN REQUEST TO ZENITH MARKETING GROUP, INC., 303 WEST MAIN STREET, SUITE 200, FREEHOLD, NJ 07728.

21st Services
AI Credit
AIG
AIG of NY
Allianz
Allianz of NY
Allstate of NY
American General
American General of NY
American National
APPS
Assurity
AXA Equitable
Aviva
AVS Underwriting

Banner Life
Cambridge Financing
Chase Insurance
Clinical Reference Lab
(CRL)
CMS II
Companion of NY
Concord Capital Funding
Coventry First
Credit Suisse
EMSI
Enterprise Bank & Trust
ExamOne
Express Imaging Services
First Penn Pacific

First MetLife Investors
Fort Dearborn
Fortris
Genworth Life and Annuity
Genworth Life of NY
Goldman Sachs
Guardian
ING/USA
Insurative Premium Finance
John Hancock
Life of the Southwest
Lincoln Benefit Life
Lincoln Financial Group
Longboat Funding
Massachusetts Mutual

MetLife
Mutual of Omaha
National Life Insurance Company
Nationwide Financial
North American Life & Health
North American Life & Health of NY
Old Mutual
Peachtree Life Settlements
Penn Mutual
PFG HYBRID
Phoenix Life
Portamedic
Presidential
Principal Financial Group
Protective Life & Annuity of NY

Pruco Life Insurance Company
Pruco Life Insurance Co. of NJ
Prudential Insurance Co. of America
Reliastar
Reliastar of NY
Ridge Capital Flexible
Premium Finance
SBLI of Mass.
Security Life of Denver
Security Mutual
Security Mutual of NY
Sentinel
Settlement Benefits Assoc.
Southland
Standard

Sun Life Financial
Transamerica
Union Central
United of Omaha
US Life of NY
West Coast
William Penn
Zenith Marketing Group